

2020-21

# Benefits Summary

## COBRA/Retiree

Look inside for important information about how to use your PEHP benefits.



PROUDLY SERVING UTAH PUBLIC EMPLOYEES



# COBRA/Retiree

## 2020-21

### COBRA/Retiree Benefits Summary

#### **COBRA/RETIREE**

##### Benefits Summary

Effective July 2020

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This Benefits Summary should be used in conjunction with the PEHP Master Policy. It contains information that only applies to PEHP subscribers on COBRA or who are early retirees and their eligible dependents. Members of any other PEHP plan should refer to the applicable publications for their coverage.

It is important to familiarize yourself with the information provided in this Benefits Summary and the PEHP Master Policy to best utilize your medical plan. The Master Policy is available by calling PEHP. You may also view it at [www.pehp.org](http://www.pehp.org).

This Benefits Summary is for informational purposes only and is intended to give a general overview of the benefits available under those sections of PEHP designated on the front cover. This Benefits Summary is not a legal document and does not create or address all of the benefits and/or rights and obligations of PEHP. The PEHP Master Policy, which creates the rights and obligations of PEHP and its members, is available upon request from PEHP and online at [www.pehp.org](http://www.pehp.org). All questions concerning rights and obligations regarding your PEHP plan should be directed to PEHP.

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# Welcome to PEHP

We want to make accessing and understanding your healthcare benefits simple. This Benefits Summary contains important information on how best to use PEHP's comprehensive benefits.

Please contact the following PEHP departments or affiliates if you have questions.

## ON THE WEB

» ..... [www.pehp.org](http://www.pehp.org)

Create a PEHP for Members account at [www.pehp.org](http://www.pehp.org) to review your claims history, get important information through our Message Center, see a comprehensive list of your coverages, find and compare providers in your network, access Healthy Utah rebate information, check your FLEX\$ account balance, and more.

## CUSTOMER SERVICE

..... 801-366-7555  
..... or 800-765-7347

Weekdays from 8 a.m. to 5:30 p.m.

Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

## PREAUTHORIZATION

» Inpatient hospital preauthorization..... 801-366-7755  
..... or 800-753-7754

## MENTAL HEALTH/SUBSTANCE ABUSE PREAUTHORIZATION

» PEHP Customer Service ..... 801-366-7755  
..... or 800-765-7347

## PRESCRIPTION DRUG BENEFITS

» PEHP Customer Service ..... 801-366-7555  
..... or 800-765-7347

» Express Scripts ..... 800-903-4725  
..... [www.express-scripts.com](http://www.express-scripts.com)

## SPECIALTY PHARMACY

» Accredo ..... 800-501-7260

## GROUP TERM LIFE AND AD&D

» PEHP Life and AD&D..... 801-366-7495

## HEALTH SAVINGS ACCOUNTS (HSA)

» PEHP FLEX\$ Department ..... 801-366-7503  
..... or 800-753-7703

» HealthEquity ..... 866-960-8058  
..... [www.healthequity.com/stateofutah](http://www.healthequity.com/stateofutah)

## PRENATAL AND POSTPARTUM PROGRAM

» PEHP WeeCare..... 801-366-7400  
..... or 855-366-7400  
..... [www.pehp.org/weecare](http://www.pehp.org/weecare)

## WELLNESS AND DISEASE MANAGEMENT

» PEHP Healthy Utah ..... 801-366-7300  
..... or 855-366-7300  
..... [www.pehp.org/healthyutah](http://www.pehp.org/healthyutah)

» PEHP Health Coaching ..... 801-366-7300  
..... or 855-366-7300

## VALUE-ADDED BENEFITS PROGRAM

» PEHPplus..... [www.pehp.org/plus](http://www.pehp.org/plus)  
» Blomquist Hale..... 800-926-9619  
..... [www.blomquisthale.com](http://www.blomquisthale.com)

## ONLINE ENROLLMENT HELP LINE

..... 801-366-7410  
..... or 800-753-7410

## CLAIMS MAILING ADDRESS

PEHP

560 East 200 South

Salt Lake City, UT 84102-2004

# Benefits Changes & Reminders

## Chronic Medications Covered Before Deductible

This is a benefit for STAR HSA Plan members who no longer have to meet their deductible before getting certain chronic medications covered under the plan. [www.pehp.org](http://www.pehp.org) for details.

## New Prescription Cost Tool

Find drug options for your health condition, compare prices at different pharmacies, and see if cash back is available for your medication. Visit [www.pehp.org](http://www.pehp.org) for details.

## Get Up to \$2,000 in Cash Back

You can now share in the savings when you choose a lower-cost provider. Find out about cash back services using PEHP's new Cost Comparison Tool. Look for the green phone with a dollar sign. Visit [www.pehp.org](http://www.pehp.org) for details.

## Send Secure Messages to PEHP

Have a question or can't find what you're looking for online? Log in to [PEHP for Members](#) and send us your questions via the Message Center. Click the Message Center icon after you login to your PEHP account.

## Health Benefit Advisors

Need help deciding which plan to choose, whether to be covered by more than one plan, or different cost options for a service? Call a PEHP Health Benefit Advisor at 801-366-7555.

## E-Care

Consider consulting a doctor remotely with your smartphone from Intermountain Connect Care (all networks) or University of Utah Health Virtual Visits (Summit only). It's convenient and costs less.

## Crisis & Life Assistance Counseling

You have access to counseling services with [Blomquist Hale Employee Assistance](#). Crisis counseling is also available 24/7 and always confidential. PEHP pays 100% of the cost. Call 1-800-926-9619 for an appointment.

# Autism Spectrum Disorder Benefit

## **The benefit covers behavioral health treatment (ABA Therapy).**

A brief overview of PEHP's Autism Spectrum Disorder coverage:

- » Please call PEHP (801-366-7555 or 800-765-7347) for information about which autism spectrum disorders and services are covered.
- » Therapeutic care includes services provided by speech therapists, occupational therapists, or physical therapists.
- » Eligible Autism Spectrum Disorder services do not accrue separately, and are subject to the medical plan's visit limits, regular cost sharing limitations – deductibles, co-payments, and coinsurance – and would apply to the out-of-pocket maximum.
- » Mental health and speech therapy services require Preauthorization.
- » No benefits for services received from out-of-network Providers. List of in-network providers is available at [PEHP for Members](#) or by calling PEHP (801-366-7555 or 800-765-7347).
- » Regular medical benefits will apply (see benefits grid for applicable co-pay and coinsurance).



# PEHP Value Providers



## MEDICAL

**The STAR Plan »** 25% discount on what you would normally pay an in-network provider

**Traditional Plan »** \$10 office co-pay

### SALT LAKE CITY

#### Midtown Clinic

230 South 500 East, Suite 510 | **801-320-5660**

#### RC Willey Employee Clinic

2301 South 300 West | **801-464-7900**

#### WesTech Wellness Center

3605 S West Temple | **801-506-0000**

### NORTH SALT LAKE

#### Orbit Employee Clinic

845 Overland St. | **801-951-5888**

#### FJM Clinic

31 N Redwood Rd, Suite 2 | **801-624-1634**

### CLEARFIELD

#### Futura Onsite Clinic

11 H Street | **801-774-3265**

### LAYTON

#### Onsite Care at Davis Hospital

1580 W. Antelope Dr, Suite 110 | **801-807-7699**

### OGDEN

#### FJM Clinic

1104 Country Hills Dr, Ste. 110 | **801-624-1633**

### OREM

#### Blendtec Health and Wellness Clinic

1206 S 1680 W | **801-225-1281**

### LEHI

#### OnSite Care at Mountain Point Medical

3000 Triumph Blvd, Ste. 320 | **801-753-4600**



## E-CARE/TELEMEDICINE

Visit a doctor online anytime, anywhere.

- » Eye infections
- » Painful urination
- » Joint pain or strains
- » Minor skin problems

**STAR HSA Plan »** \$59 per visit or \$10 per visit after deductible; For UofU virtual visits: \$49 per visit or \$10 per visit after deductible

**Traditional Plan »** \$10 per visit

**Intermountain Connect Care »** available on all networks

**University of Utah Health Virtual Visits »**  
available on Summit network only



*Check with your employer to see which medical and dental plans are available to you. You must be enrolled in an active PEHP medical plan to visit a medical clinic. You must be enrolled in an active PEHP dental plan to visit a dental clinic.*



# PEHP Value Providers



## COLONOSCOPY

**Get Cash Back »** Get cash back\* when you get your colonoscopy from one of these Value Providers. You must call PEHP prior to service to be eligible for cash back. You need to get the colonoscopy in the provider's office or at an ambulatory surgical center to be eligible for cash back as this doesn't apply to hospitals, even if your doctor determines you must do it there. Remember you'll always get the best pricing when you use a PEHP Value Provider.

### Utah Gastroenterology

*If you're on the Advantage Network, there is only one Utah Gastroenterology location where cash back is available. Summit, Capital, and Preferred Network members may use any of the facilities listed below and receive cash back.*

- 6360 S 3000 E Ste 310, SLC (**Advantage**)
- 620 Medical Dr Ste 205, Bountiful
- 1250 E 3900 S Ste 360, SLC
- 13953 S Bangerter Pkwy, Draper
- 12391 S 4000 W, Riverton
- 3000 N Triumph Blvd, Ste 340, Lehi

### Granite Peaks Gastroenterology

- 1393 E Sego Lilly Dr., Sandy
- 3000 N Triumph Blvd Ste 330, Lehi

### Revere Health

- 1055 N. 500 W., Provo
- 1175 E. 50 S., American Fork

#### Preventive Colonoscopy 50+

**You must call PEHP prior to service to get cash back.** The cash back applies even when it's preventive and covered at 100%.

**Tip:** Be sure the anesthesia is considered "moderate or conscious" sedation as general anesthesia isn't covered as part of the preventive service unless pre-authorized through PEHP. Also be aware that sometimes the colonoscopy can result in additional treatment or diagnosis where you would be responsible for some of the cost based on your benefit cost share.

*\*Please note cash back is subject to income taxes.*



## PRESCRIPTION ASSISTANCE PROGRAMS

PEHP has identified several medication-assistance programs which may help to reduce the cost of your medication. See if you qualify.

#### Rx Help Centers®

<http://rxhelpcenter.org/>

#### Patient Access Network Foundation®

<https://panfoundation.org/index.php/en/>

#### Patient Advocate Foundation®

<http://www.patientadvocate.org/>

#### HealthWell Foundation®

<https://www.healthwellfoundation.org/>



# PEHP Value Providers



## LABORATORIES

Visit these labs for exclusive PEHP member savings.

### **MULTIPLE LOCATIONS**

The following laboratories have more than one location. For the location near you, visit the [Provider Lookup](http://www.pehp.org/ProviderLookup) at [www.pehp.org](http://www.pehp.org).

#### **Accupath Diagnostics**

Advantage and Summit networks

#### **Cedar Diagnostics LLC**

Advantage and Summit networks

#### **Esoterix**

Advantage network only

#### **Labcorp Inc**

Advantage and Summit networks

#### **Pathology Associates Medical Labs**

Summit network only

#### **Quest Diagnostics**

Summit network only

### **BOUNTIFUL**

#### **Bountiful Health Center Lab**

390 N Main St. | **801-294-1150**

Advantage network only

### **MURRAY**

#### **Intermountain Central Lab**

5252 S Intermountain Dr. | **801-535-8163**

Summit network only

### **SALT LAKE CITY**

#### **IHC Health Center Salt Lake Clinic**

333 S 900 E | **801-535-8163**

Advantage and Summit networks

### **OUT-OF-STATE**

#### **ALBUQUERQUE, N.M.**

#### **Tricare Reference Laboratories**

1001 Woodward Pl. NE | **505-938-8803**

Summit network only

*Check with your employer to see which medical and dental plans are available to you. You must be enrolled in an active PEHP medical plan to visit a medical clinic. You must be enrolled in an active PEHP dental plan to visit a dental clinic.*

# PEHP Online Tools

## Access Benefits and Claims

### WWW.PEHP.ORG

Access important benefit tools and information by creating an online personal account at [www.pehp.org](http://www.pehp.org).

- » Receive important messages about your benefits and coverage through our Message Center.
- » See your claims history — including medical, dental, and pharmacy. Search claims histories by member, plan, and date range.
- » Become a savvy consumer using our Cost & Quality Tools.
- » View and print plan documents, such as forms and Master Policies.
- » Get a simple breakdown of the PEHP benefits in which you're enrolled.
- » Track your biometric results and access Healthy Utah rebates and resources.
- » Access your FLEX\$ account.
- » Cut down on clutter by opting in to paperless delivery of explanation of benefits (EOBs). Opt to receive EOBs by email, rather than paper forms through regular mail, and you'll get an email every time a new one is available.
- » Change your mailing address.

## Find a Provider

### WWW.PEHP.ORG

Looking for a provider, clinic, or facility that is contracted with your plan? Look no farther than [www.pehp.org](http://www.pehp.org). Go online to search for providers by name, specialty, or location.

## Access Your Pharmacy Account

### WWW.EXPRESS-SCRIPTS.COM

Create an account with Express Scripts, PEHP's pharmacy benefit manager, and get customized information that will help you get your medications quickly and at the best price.

Go to [www.express-scripts.com](http://www.express-scripts.com) to create an account. All you need is your PEHP ID card and you're on your way.

You'll be able to:

- » Check prices.
- » Check an order status.
- » Locate a pharmacy.
- » Refill or renew a prescription.
- » Get mail-order instructions.
- » Find detailed information specific to your plan, such as drug coverage, co-pays, and cost-saving alternatives.

## Summit

**Steward Health, MountainStar, and University of Utah Health Care** providers and facilities. You can also see Advantage providers on the Summit network, but your benefits will pay less.

### Participating Hospitals

#### Beaver County

Beaver Valley Hospital  
Milford Valley Memorial Hospital

#### Box Elder County

Bear River Valley Hospital  
Brigham City Community Hospital

#### Cache County

Cache Valley Hospital

#### Carbon County

Castlevue Hospital

#### Davis County

Lakeview Hospital  
Davis Hospital

#### Duchesne County

Uintah Basin Medical Center

#### Garfield County

Garfield Memorial Hospital

#### Grand County

Moab Regional Hospital

#### Iron County

Cedar City Hospital

#### Juab County

Central Valley Medical Center

#### Kane County

Kane County Hospital

#### Millard County

Delta Community Hospital  
Fillmore Community Hospital

#### Salt Lake County

Huntsman Cancer Hospital  
Jordan Valley Hospital  
Jordan Valley Hospital - West  
Lone Peak Hospital  
Primary Children's Medical Center

#### Salt Lake County (cont.)

Riverton Children's Unit  
St. Marks Hospital  
Salt Lake Regional Medical Center  
University of Utah Hospital  
University Orthopaedic Center

#### San Juan County

Blue Mountain Hospital  
San Juan Hospital

#### Sanpete County

Gunnison Valley Hospital  
Sanpete Valley Hospital

#### Sevier County

Sevier Valley Hospital

#### Summit County

Park City Medical Center

#### Tooele County

Mountain West Medical Center

#### Uintah County

Ashley Regional Medical Center

#### Utah County

Mountain View Hospital  
Timpanogos Regional Hospital  
Mountain Point Medical Center

#### Wasatch County

Heber Valley Medical Center

#### Washington County

Dixie Regional Medical Center

#### Weber County

Ogden Regional Medical Center

#### Out-of-State – Colorado

St. Mary's Hospital – Grand Junction  
Southwest Memorial Hospital – Cortez

## Advantage

**Intermountain Healthcare (IHC)** providers and facilities. You can also see Summit providers on the Advantage network, but your benefits will pay less.

### Participating Hospitals

#### Beaver County

Beaver Valley Hospital  
Milford Valley Memorial Hospital

#### Box Elder County

Bear River Valley Hospital

#### Cache County

Logan Regional Hospital

#### Carbon County

Castlevue Hospital

#### Davis County

Davis Hospital  
Intermountain Layton Hospital

#### Duchesne County

Uintah Basin Medical Center

#### Garfield County

Garfield Memorial Hospital

#### Grand County

Moab Regional Hospital

#### Iron County

Cedar City Hospital

#### Juab County

Central Valley Medical Center

#### Kane County

Kane County Hospital

#### Millard County

Delta Community Hospital  
Fillmore Community Hospital

#### Salt Lake County

Alta View Hospital  
Intermountain Medical Center  
The Orthopedic Specialty Hospital (TOSH)  
LDS Hospital

#### Salt Lake County (cont.)

Primary Children's Medical Center  
Riverton Hospital

#### San Juan County

Blue Mountain Hospital  
San Juan Hospital

#### Sanpete County

Gunnison Valley Hospital  
Sanpete Valley Hospital

#### Sevier County

Sevier Valley Hospital

#### Summit County

Park City Medical Center

#### Tooele County

Mountain West Medical Center

#### Uintah County

Ashley Regional Medical Center

#### Utah County

American Fork Hospital  
Orem Community Hospital  
Utah Valley Hospital

#### Wasatch County

Heber Valley Medical Center

#### Washington County

Dixie Regional Medical Center

#### Weber County

McKay-Dee Hospital

#### Out-of-State – Colorado

St. Mary's Hospital – Grand Junction  
Southwest Memorial Hospital – Cortez

## Preferred

Consists of all providers and facilities in both the Summit and Advantage networks.

### Non-Contracted Providers

PEHP doesn't pay for any services from certain providers, even if you have an out-of-network benefit. Find participating providers and [see a list of Non-Contracted Providers](#) at [www.pehp.org](http://www.pehp.org).

# Understanding Your Benefits Grid

DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
<b>Plan year Deductible</b> <i>Does not apply to Out-of-Pocket Maximum</i>	1	Single plans: \$350 Double/family plans: \$350 per person <i>One person cannot meet more than \$350</i>
<b>Plan year Out-of-Pocket Maximum**</b>	2	Single plans: \$3,000 Double plans: \$3,000 per person, \$6,000 per family Family plans: \$3,000 per person, \$6,000 per family <i>One person cannot meet more than \$3,000</i>
ANNUAL PREVENTIVE CARE		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations.</i>		No charge
PHARMACY SERVICES		
<b>30-day Pharmacy</b> <i>Mail-order</i>		Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance.
<b>90-day Pharmacy</b> <i>Mail-order only</i>		Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance.

\*You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers. They may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.  
\*\*Some services on your plan are payable at a reduced benefit of 50% of In-Network Rate or 30% of In-Network Rate. These services do not apply to any out-of-pocket maximum. Deductible may apply. Refer to the Master Policy for specific criteria for the benefits listed above, as well as information on limitations and exclusions.

WWW.PEHP.ORG

## 1 MEDICAL DEDUCTIBLE

The set dollar amount that you must pay for yourself and/or your family members before PEHP begins to pay for covered medical benefits. Some plans might also have a separate pharmacy deductible.

## 2 PLAN YEAR OUT-OF-POCKET MAXIMUM

The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance (and deductibles for STAR plans). Some plans might also have separate out-of-pocket maximums for mental health & substance abuse and for specialty drug charges.

### CO-PAY

A specific amount you pay directly to a provider when you receive covered services. This can be either a fixed dollar amount or a percentage of the PEHP In-Network Rate.

### IN-NETWORK

In-network benefits apply when you receive covered services from in-network providers. You are responsible to pay the applicable copayment.

### OUT-OF-NETWORK

If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services. You are responsible to pay the applicable co-pay, plus the difference between the billed amount and PEHP's In-Network Rate.

### IN-NETWORK RATE

The amount in-network providers have agreed to accept as payment in full. If you use an out-of-network provider, you will be responsible to pay your portion of the costs as well as the difference between what the provider bills and the In-Network Rate (balance billing). In this case, the allowed amount is based on our in-network rates for the same service.

*For more definitions, please see the Master Policy.*

# Understanding In-Network Providers

It's important to understand the difference between in-network and out-of-network providers and how the In-Network Rate works to avoid unexpected charges.

## In-Network Rate

Doctors and facilities contracted in your network — in-network providers — have agreed not to charge more than PEHP's In-Network Rate for specific services. Your benefits are often described as a percentage of the In-Network Rate. With in-network providers, you pay a predictable amount of the bill: the remaining percentage of the In-Network Rate. For example, if PEHP pays your benefit at 80% of In-Network Rate, your portion of the bill generally won't exceed 20% of the In-Network Rate.

## Balance Billing

It's a different story with out-of-network providers. They may charge more than the In-Network Rate unless they have an agreement with you not to. These doctors and facilities, who aren't a part of your network, have no pricing agreement with PEHP. The portion of the benefit PEHP pays is based on what we would pay a n in-network provider. You'll be billed the full amount that the provider charges above the In-Network Rate. This is called "balance billing."

Understand that charges to you may be substantial if you see an out-of-network provider. Your plan generally pays a smaller percentage of the In-Network Rate, and you'll also be billed for any amount charged above the In-Network Rate.

## Negotiate a Price

**Don't get Balance Billed:** Although non-contracted providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

The amount you pay for charges above the In-Network Rate won't apply to your deductible or out-of-pocket maximum.

## Consider Your Options

Carefully choose your network based on the group of medical providers you prefer or are more likely to see. See the Medical Networks comparison in this book or go to [www.pehp.org](http://www.pehp.org) and log in to PEHP for Members to see which network includes your doctors.

Ask questions before you get medical care. Make sure every person and every facility involved is contracted in your network.

Although out-of-network providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

[Learn More » Your Network and Your Money](#)

# Health Savings Accounts

## About Health Savings Account (HSA)

An HSA is a tax-advantaged, interest-bearing account. Your money goes in tax free, grows tax free, and can be spent on qualified health expenses tax free. An HSA can be a great way to save for health expenses in both the short and long term.

An HSA is similar to a flexible spending account; you contribute pre-tax dollars to pay for eligible health expenses.

An HSA has several advantages. You never have to forfeit what you don't spend. Your money carries over from year-to-year and even from employer-to-employer. All the while, an HSA can earn tax-free interest in a savings account.

The STAR Plan employer HSA contributions for 2020-21 will be \$909.22 for a single plan and \$1,826.76 for double plans, and \$1,918.54 for family plans. Contributions will be frontloaded semi-annually, half by the end of July 2020 and half by the end of January 2021.

Consumer Plus Plan employer HSA contributions for 2020-21 will be \$1,824.68 for a single plan and \$3,649.62 for a double and family plan. Contributions will be frontloaded semi-annually, half by the end of July 2020 and half by the end of January 2021.

You can also contribute to an HSA much like you would a 401(k). You decide how many pre-tax dollars you want withheld from each paycheck, and earnings grow tax free.

Eligible HSA expenses include deductibles and Co-Insurance, as well as health expenses that are eligible to be paid with a medical flexible spending account.

## HSA Eligibility

To be eligible for the HSA the following things must apply to you:

- » You're not participating in or covered by a flexible spending account (FSA) or HRA or their balances will be \$0 on or before June 30.
- » You're not covered by another health plan (unless it's another HSA-qualified plan).
- » You're not covered by Medicare or TRICARE.
- » You're not a dependent of another taxpayer.

## Banking with HealthEquity

PEHP has an arrangement with HealthEquity to handle your HSA. The COBRA/Retiree will make your HSA contributions through PEHP to HealthEquity into your account. You are responsible for the management of your HSA funds once they are in the account.

## For More Information

For more information about HSAs go to:  
[www.pehp.org/thestarplan](http://www.pehp.org/thestarplan), [www.ustreas.gov](http://www.ustreas.gov), or  
[www.irs.gov](http://www.irs.gov).

## Consumer Plus Plan

For Consumer Plus Plan members double covered through the State, be aware of the IRS limit and notify PEHP to only accept IRS limit.

### 2020 HSA IRS limits

**Single:** \$3,550

**Double/Family:** \$7,100

**55+ Catch-up contribution:** \$1,000

**Learn more:**  
[www.healthequity.com/stateofutah](http://www.healthequity.com/stateofutah)





## STAR HSA

Summit, Advantage &amp; Preferred

### MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b>	Single plans: \$1,500 Double/family plans: \$3,000 <i>One person or a combination can meet the \$3,000 double/family deductible</i>	
<b>Plan year Out-of-Pocket Maximum</b> <i>Includes amounts applied to Deductibles, Co-Insurance and prescription drugs</i>	Single plans: \$2,500 Double plans: \$5,000 Family plans: \$7,500 <i>One person or a combination can meet the \$7,500 family maximum</i>	
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	40% after deductible
<b>PROFESSIONAL SERVICES</b>		
<b>PEHP e-Care</b>	<b>Medical:</b> \$10 co-pay per visit after deductible	Not applicable
<b>PEHP Value Clinics</b>	<b>Medical:</b> 20% after deductible	Not applicable
<b>Primary Care Visits</b>   <i>Includes office surgeries and inpatient visits</i>	20% after deductible	40% after deductible
<b>Specialist Visits</b>   <i>Includes office surgeries and inpatient visits</i>	20% after deductible	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	20% after deductible	20% after deductible
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>Mental Health and Substance Abuse</b> <i>No preauthorization required for outpatient service. Inpatient services require preauthorization</i>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS</b>   <i>All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost. \$25 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

\*You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.



	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>PRESCRIPTION DRUGS</b>   All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a>		
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	<b>Tier A:</b> 40%. No maximum co-pay <b>Tier B:</b> 50%. No maximum co-pay
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay <b>Tier B:</b> 30%. \$225 maximum co-pay <b>Tier C:</b> 20%. No maximum co-pay	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	40% after deductible
<b>Urgent Care Facility</b>	20% after deductible	40% after deductible
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	20% after deductible	20% after deductible
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Physical and Occupational Therapy</b> <i>Outpatient – Up to 20 combined visits per plan year.</i>	20% after deductible	40% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical &amp; Surgical</b> <i>All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details</i>	20% after deductible	40% after deductible
<b>Skilled Nursing Facility</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Hospice</b>	20% after deductible	40% after deductible
<b>Rehabilitation</b> <i>Up to 45 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Mental Health &amp; Substance Abuse</b> <i>Requires Preauthorization</i>	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>   <i>See Master Policy for benefit limits</i>	20% after deductible, up to \$4,000 per adoption or up to \$4,000 per lifetime for ART	
<b>Allergy Serum</b>	20% after deductible	40% after deductible
<b>Chiropractic care</b>   <i>Up to 10 visits per plan year</i>	20% after deductible	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year</i>	20% after deductible	40% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy for details.</i>	50% after deductible	70% after deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical. Up to \$1,000 lifetime maximum</i>	50% after deductible	70% after deductible



## Traditional (Non-HSA)

Summit, Advantage &amp; Preferred

### MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Does not apply to Out-of-Pocket Maximum</i>	Single plans: \$350 Double/family plans: \$350 per person, \$700 per family <i>One person cannot meet more than \$350</i>	
<b>Plan year Out-of-Pocket Maximum**</b>	Single plans: \$3,000 Double plans: \$3,000 per person, \$6,000 per double Family plans: \$3,000 per person, \$9,000 per family <i>One person cannot meet more than \$3,000</i>	
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	40% after deductible
<b>PROFESSIONAL SERVICES</b>		
<b>PEHP e-Care</b>	Medical: \$10 co-pay per visit	Not applicable
<b>PEHP Value Clinics</b>	\$10 co-pay per visit	Not applicable
<b>Primary Care Visits</b>   <i>Includes office surgeries and inpatient visits</i>	\$25 co-pay per visit IHC: \$35 co-pay per visit for Summit and Preferred networks University of Utah Medical Group: \$35 co-pay per visit	40% after deductible
<b>Specialist Visits</b>   <i>Includes office surgeries and inpatient visits</i>	\$35 co-pay per visit IHC: \$45 co-pay per visit for Summit and Preferred networks University of Utah Medical Group: \$45 co-pay per visit	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	\$35 co-pay per visit	\$35 co-pay per visit
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>Mental Health and Substance Abuse</b> <i>No preauthorization required for outpatient service. Inpatient services require preauthorization</i>	\$35 co-pay per visit University of Utah Medical Group: \$45 co-pay per visit	40% after deductible
<b>PRESCRIPTION DRUGS</b>   <i>For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost. \$25 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

\*You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.

\*\*Some services on your plan are payable at a reduced benefit of 50% of In-Network Rate or 20% of In-Network Rate. These services do not apply to any out-of-pocket maximum.

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>SPECIALTY DRUGS</b>   For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a>		
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20% after deductible. No maximum co-pay <b>Tier B:</b> 30% after deductible. No maximum co-pay	<b>Tier A:</b> 40% after deductible. No maximum co-pay <b>Tier B:</b> 50% after deductible. No maximum co-pay
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay <b>Tier B:</b> 30%. \$225 maximum co-pay <b>Tier C:</b> 20%. No maximum co-pay	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	40% after deductible
<b>Urgent Care Facility</b>	\$45 co-pay per visit	40% after deductible
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	20% of In-Network Rate, minimum \$150 co-pay per visit	20% of In-Network Rate, minimum \$150 co-pay per visit
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less, when the only services performed are diagnostic testing</i>	20% after deductible	40% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Physical and Occupational Therapy</b> <i>Outpatient – Up to 20 combined visits per plan year.</i>	Applicable co-pay per visit	40% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical &amp; Surgical</b> <i>All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details</i>	20% after deductible	40% after deductible
<b>Skilled Nursing Facility</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Hospice</b>	20% after deductible	40% after deductible
<b>Rehabilitation</b> <i>Up to 45 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible
<b>Mental Health &amp; Substance Abuse</b> <i>Requires Preauthorization</i>	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>   <i>See Master Policy for benefit limits</i>	20% after deductible, up to \$4,000 per adoption or up to \$4,000 per lifetime for ART	
<b>Allergy Serum</b>	20% after deductible	40% after deductible
<b>Chiropractic care</b>   <i>Up to 10 visits per plan year</i>	Applicable office co-pay per visit	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year</i>	20% after deductible	40% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy for details.</i>	50% after deductible	70% after deductible
<b>Temporomandibular Joint Dysfunction**</b> <i>Non-surgical. Up to \$1,000 lifetime maximum</i>	50% after deductible	70% after deductible

**Important Notice:** Consumer Plus is administered by its own Master Policy. The benefits are very different from the Traditional or STAR plans. Find details in the Consumer Plus Master Policy.

**You may not select Consumer Plus unless you are currently on The STAR Plan.**

**If you choose Consumer Plus, you must enroll in an HSA-qualified plan the next enrollment period.**



## Consumer Plus

(HSA-Qualified)

Summit, Advantage & Preferred

### MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b>	Single plans: \$3,000 Double/family plans: \$6,000 <i>One person or a combination can meet the \$6,000 double/family deductible</i>	
<b>Plan year Out-of-Pocket Maximum</b> <i>Includes amounts applied to Deductibles, Co-Insurance and prescription drugs</i>	Single plans: \$6,050 Double/family plans: \$12,100 <i>One person can only meet \$8,150, or a combination can meet the \$12,100 double/family maximum</i>	
<b>WELL-CARE PROGRAM   ANNUAL ROUTINE CARE</b>		
<b>Affordable Care Act Preventive Services</b> <i>See Master Policy for complete list</i>	No charge	50% of In-Network Rate after deductible
<b>Vision Screening</b> <i>One time between ages 3 and 5</i>	No charge	50% of In-Network Rate after deductible
<b>Pediatric Dental Services**</b> <i>Routine cleaning, exams, x-rays and fluoride. Two times per plan year. Age 3 through the end of the month in which the Member turns 19 years of age. Sealants once every five years. See Master Policy for details.</i>	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
<b>Pediatric Vision Services</b> <i>Lenses only. One time per plan year. Age 3 through the end of the month in which the Member turns 19 years of age. Can see Provider of choice</i>	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
<b>PROFESSIONAL SERVICES</b>		
<b>PEHP e-Care</b>	<b>Medical:</b> \$10 co-pay per visit after deductible	Not applicable
<b>PEHP Value Clinics</b>	<b>Medical:</b> 30% after deductible	Not applicable
<b>Primary Care Visits</b>   <i>Includes office surgeries and inpatient visits</i>	30% after deductible	40% after deductible
<b>Specialist Visits</b>   <i>Includes office surgeries and inpatient visits</i>	30% after deductible	40% after deductible
<b>Surgery and Anesthesia</b>	30% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	30% after deductible	30% after deductible
<b>Diagnostic Tests, Labs, X-rays</b>	30% after deductible	50% after deductible
<b>Mental Health and Substance Abuse</b> <i>No preauthorization required for outpatient service. Inpatient services require preauthorization</i>	30% after deductible	40% after deductible

\*You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.

\*\*Payable only as secondary to a dental plan or if member does not have a separate dental plan.

# COBRA/Retiree 2020-21 » Consumer Plus Plan » Benefits Grids

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>PRESCRIPTION DRUGS</b>   All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Preferred generic:</b> 30% of discounted cost <b>Preferred brand name:</b> 30% of discounted cost	Plan pays up to the discounted cost. Member pays any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	30% of In-Network Rate. No maximum Co-Insurance	Not covered
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	30% of In-Network Rate. No maximum Co-Insurance	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	30% after deductible	50% after deductible
<b>Urgent Care Facility</b>	30% after deductible	50% after deductible
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	30% after deductible	30% after deductible
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	30% after deductible	
<b>Diagnostic Tests, Labs, X-rays</b>	30% after deductible	50% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	30% after deductible	50% after deductible
<b>Physical, Occupational and Speech Therapy</b> <i>Outpatient – Up to 10 combined visits per plan year.</i>	30% after deductible	50% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical &amp; Surgical</b> <i>All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details</i>	30% after deductible	50% after deductible
<b>Skilled Nursing Facility and Rehabilitation</b> <i>Non-custodial. Up to 30 days per plan year. Requires preauthorization</i>	30% after deductible	50% after deductible
<b>Hospice</b>	30% after deductible	50% after deductible
<b>Mental Health &amp; Substance Abuse</b> <i>Requires Preauthorization</i>	30% after deductible	50% after deductible



	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>   <i>See Master Policy for benefit limits</i>	30% after deductible, up to \$4,000 per adoption	
<b>Allergy Serum</b>	30% after deductible	50% after deductible
<b>Chiropractic care</b>	Not covered	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	30% after deductible Summit Network: Alpine Home Medical	50% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	30% after deductible	50% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 30 visits per plan year</i>	30% after deductible	50% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	30% after deductible	50% after deductible
<b>Infertility Services</b>	Not covered	Not covered
<b>Sleep Studies and Sleep Equipment</b>	Not covered	Not covered
<b>Temporomandibular Joint Dysfunction</b>	Not covered	Not covered

# Wellness and Value-Added Benefits

## PEHP Healthy Utah

PEHP Healthy Utah is an employee health promotion program aimed at enhancing the well-being of members by increasing awareness of health risks and providing support in making health-related lifestyle changes. PEHP Healthy Utah offers a variety of programs, services, cash incentives, and resources to help members get and stay well.

Subscribers and their spouses are eligible to attend one Healthy Utah biometric testing session each plan year free of charge. PEHP Healthy Utah is offered at the discretion of the Employer.

Members on the Consumer Plus Plan are not eligible for rebates.

### FOR MORE INFORMATION

#### PEHP Healthy Utah

801-366-7300 or 855-366-7300

» Email: [healthyutah@pehp.org](mailto:healthyutah@pehp.org)

» Web: [www.pehp.org/healthyutah](http://www.pehp.org/healthyutah)

## PEHP WeeCare

PEHP WeeCare is a pregnancy and postpartum program provided to support and educate PEHP members. PEHP WeeCare's goal is to help expectant mothers have the healthiest and safest pregnancy possible. Members can enroll online at any time during pregnancy up to 12 months after delivery.

Participate in PEHP WeeCare and you may qualify for free prenatal vitamins, books and educational resources. Cash incentives are available for enrolling and for postpartum weight loss. While PEHP WeeCare is not intended to take the place of your doctor, it's another resource for answers to questions during pregnancy.

This benefit is not available on the Consumer Plus Plan.

### FOR MORE INFORMATION

#### PEHP WeeCare

P.O. Box 3503

Salt Lake City, Utah 84110-3503

801-366-7400 | 855-366-7400

» E-mail: [weecare@pehp.org](mailto:weecare@pehp.org)

» Web: [www.pehp.org/weecare](http://www.pehp.org/weecare)

## PEHP Health Coaching

This lifestyle behavior change program provides education, support, and accountability to help you succeed in meeting your health and weight management goals. Available to members, spouses and dependents age 6 and older.

This benefit is not available on the Consumer Plus Plan.

### FOR MORE INFORMATION

#### PEHP Health Coaching

801-366-7300 | 855-366-7300

» E-mail: [healthcoaching@pehp.org](mailto:healthcoaching@pehp.org)

» Web: [www.pehp.org](http://www.pehp.org)

## PEHP Plus

PEHPplus provides savings of up to 60 percent on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. We're frequently adding new discounts, so check it out at [www.pehp.org/plus](http://www.pehp.org/plus).

## Life Assistance Counseling

PEHP pays for members to use Blomquist Hale Consulting for distressing life problems such as: marital struggles, financial difficulties, drug and alcohol issues, stress, anxiety, depression, despair, death in family, issues with children, and more. Blomquist Hale Life Assistance Counseling is a confidential counseling and wellness service provided to members and covered at 100% by PEHP.

### FOR MORE INFORMATION

Blomquist Hale, 800-926-9619

» Web: [www.blomquisthale.com](http://www.blomquisthale.com)

# PEHP Dental Care

## Introduction

PEHP wants to keep you healthy and smiling brightly. We offer dental plans that provide coverage for a full range of dental care.

When you use in-network providers, you pay a coinsurance and PEHP pays the balance. When you use out-of-network providers, PEHP pays a specified portion of the In-Network Rate (In-Network Rate), and you are responsible for the balance.

There is no deductible for Diagnostic or Preventive services.

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at [www.pehp.org](http://www.pehp.org). Call PEHP Customer Service to request a copy.

## Waiting Period for Orthodontic, Implant, and Prosthodontic Benefits

There is a Waiting Period of six months from the effective date of coverage for Orthodontic, Implant, and Prosthodontic benefits unless prior continuous dental coverage of 6 months or more can be shown.

Members returning from military service will have the six-month waiting period for orthodontics waived if they reinstate their dental coverage within 90 days of their military discharge date.

## Missing Tooth Exclusion

Services to replace teeth that are missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP.

However, the plan may review the abutment teeth for eligibility of Prosthodontic benefits. The Missing Tooth Exclusion does not apply if a bridge, denture, or implant was in place at the time the coverage became effective.

## Limitations and Exclusions

Written preauthorization may be required for prosthodontic services. Preauthorization is not required for orthodontics.

Refer to the Dental Care Master Policy for complete benefit limitations, exclusions, and specific plan guidelines.

## Master Policy

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at [www.pehp.org](http://www.pehp.org). Call PEHP Customer Service to request a copy.

## COBRA/Retiree 2020-21 » Dental

If you use an Out of Network provider, your benefits will be reduced by 20%. Out of Network providers may collect charges that exceed PEHP's In Network Rate.

### Preferred Dental Care

### Traditional Dental Care

	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>				
<b>Deductible</b> (Does not apply to diagnostic or preventive services)	\$25 per member, \$75 maximum per family	\$25 per member, \$75 maximum per family	None	None
<b>Annual Benefit Max</b>	\$1,500	\$1,500	\$1,500	\$1,500
<b>DIAGNOSTIC</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
<b>Periodic Oral Examinations</b>	No Charge	20% of <a href="#">In-Network Rate</a>	No Charge	20% of In-Network Rate
<b>X-rays</b>	20% of In-Network Rate	40% of In-Network Rate	No Charge	20% of In-Network Rate
<b>PREVENTIVE</b>				
<b>Cleanings and Fluoride Solutions</b>	20% of In-Network Rate	40% of In-Network Rate	No Charge	20% of In-Network Rate
<b>Sealants</b>   Permanent molars only through age 17	20% of In-Network Rate	40% of In-Network Rate	No Charge	20% of In-Network Rate
<b>RESTORATIVE</b>				
<b>Amalgam Restoration</b>	20% of In-Network Rate AD*	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>Composite Restoration</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>ENDODONTICS</b>				
<b>Pulpotomy</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>Root Canal</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>PERIODONTICS</b>				
	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>ORAL SURGERY</b>				
<b>Extractions</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>ANESTHESIA</b>   General Anesthesia in conjunction with oral surgery or impacted teeth only				
<b>General Anesthesia</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>Prosthodontic, implant, and orthodontic services below are not eligible for six months from the date coverage begins unless prior, continuous dental coverage can be shown</b>				
<b>PROSTHODONTIC BENEFITS</b>   Preauthorization may be required				
<b>Crowns</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>Bridges</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>Dentures (partial)</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>Dentures (full)</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>IMPLANTS</b>				
<b>All related services</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>ORTHODONTIC BENEFITS</b>   6-month Waiting Period				
<b>Maximum Lifetime Benefit per Member</b>	\$1,500		\$1,500	
<b>Eligible Appliances and Procedures</b>	50% of eligible fees to plan maximum AD		50% of eligible fees to plan maximum	

**Missing Tooth Exclusion** » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with a PEHP-sponsored dental plan. Learn more in the [Dental Master Policy](#). If coverage is provided by a PEHP medical plan, then there is no dental plan coverage.

\* AD = After Deductible

If you use an Out of Network provider, your benefits will be reduced by 20%. Out of Network providers may collect charges that exceed PEHP's In Network Rate.

## Basic HSA Dental Care

Must be on STAR HSA or Consumer Plus Plan

	IN NETWORK	OUT OF NETWORK
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Deductible</b> (Does not apply to diagnostic or preventive services)	<b>\$50</b> per member, <b>\$150</b> maximum per family	<b>\$50</b> per member, <b>\$150</b> maximum per family
<b>Annual Benefit Max</b>	<b>\$500</b>	<b>\$500</b>
<b>DIAGNOSTIC</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
<b>Periodic Oral Exams</b>	No Charge	<b>20%</b> of <a href="#">In-Network Rate</a>
<b>X-rays</b>	No Charge	<b>20%</b> of In-Network Rate
<b>PREVENTIVE</b>		
<b>Cleanings and Fluoride Solutions</b>	No Charge	<b>20%</b> of In-Network Rate
<b>Sealants</b>   Permanent molars only through age 17	No Charge	<b>20%</b> of In-Network Rate
<b>RESTORATIVE</b>		
<b>Amalgam Restoration</b>	<b>50%</b> of In-Network Rate AD*	<b>70%</b> of In-Network Rate AD
<b>Composite Restoration</b>	<b>50%</b> of In-Network Rate AD	<b>70%</b> of In-Network Rate AD
<b>ENDODONTICS</b>		
Not covered		
<b>PERIODONTICS</b>		
Not covered		
<b>ORAL SURGERY</b>		
Not covered		
<b>ANESTHESIA</b>		
General Anesthesia in conjunction with oral surgery or impacted teeth		
Not covered		
<b>PROSTHODONTIC BENEFITS</b>		
Not covered		
<b>IMPLANTS</b>		
Not covered		
<b>ORTHODONTIC BENEFITS</b>		
Not covered		

## Discount HSA Dental Care

Must be on STAR HSA or Consumer Plus Plan

Discount HSA Dental offers no coverage for dental services, but you are eligible for average savings on dental services when you visit dentists in the PEHP network (find them at [www.pehp.org](http://www.pehp.org) or by calling PEHP).

» HSA Employer Contribution Amounts

- › Single: \$235
- › Double: \$430
- › Family: \$785

» If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or Regence Expressions for 3 years

» HSA Employer Contribution Amounts:

- › Single: \$75
- › Double: \$140
- › Family: \$255

» If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or Regence Expressions for 3 years

\* AD = After Deductible

# Regence Expressions<sup>SM</sup> Dental Plan

**\$0 Deductible**  
**\$1,500 Maximum**

**STATE OF UTAH**  
**Effective Date:**



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

## Benefit Summary

<b>Deductible per contract year</b>	\$0 Per Member Deductible \$0 Family Deductible
<b>Maximum benefit per contract year</b>	\$1,500 Per Member

## Understanding Your Benefits

- Once you have satisfied any applicable deductible, we pay a percentage of the allowed amount for covered services up to any maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Member Responsibility).
- We do not reimburse Dentists for charges above the allowed amount. A **Participating Dentist** will not charge you for any balances for covered services beyond your coinsurance amount. **Nonparticipating Dentists**, however, may bill you for any balances over our payment level in addition to any coinsurance amount. You can find a list of providers at our Website or by calling Customer Service.

## Covered Dental Services (Per Member)

## Member Responsibility

<b>Preventive Dental Services</b> <ul style="list-style-type: none"> <li>Bitewing x-rays: 2 per contract year</li> <li>Complete intra-oral mouth x-rays: Once in a 3-year period</li> <li>Cleanings: 2 per contract year (in lieu of periodontal maintenance)</li> <li>Oral examinations: 2 per contract year</li> <li>Panoramic mouth x-rays: Once in a 3-year period</li> <li>Sealants (bicuspid and molars only): Under 15 years of age</li> <li>Space Maintainers: Under 13 years of age</li> <li>Topical fluoride application: Under 26 years of age, 2 treatments per contract year</li> </ul>	0%
<b>Basic Dental Services</b> <ul style="list-style-type: none"> <li>Repair of Bridges, Crowns, Dentures: Coverage for adjustments and repair allowed one year of after placement</li> <li>Endodontic services including root canal treatment, pulpotomy and apicoectomy</li> <li>Emergency treatment for pain relief</li> <li>Fillings consisting of composite and amalgam restorations</li> <li>General dental anesthesia or intravenous sedation (subject to necessity)</li> <li>Uncomplicated and complex oral surgery procedures</li> <li>Periodontal maintenance: 2 per plan year (in lieu of preventive cleanings)</li> <li>Periodontal debridement: Once in a 3-year period</li> <li>Periodontal scaling and root planing: 2 per contract year</li> <li>Vestibuloplasty</li> </ul>	20%
<b>Major Dental Services</b> <ul style="list-style-type: none"> <li>Bridges: Except no benefits are provided for replacement made fewer than 5-years after placement</li> <li>Crowns: Except no benefits are provided for replacement made fewer than 5-years after placement</li> <li>Dentures (full and partial): Except no benefits are provided for replacement made fewer than 5-years after placement</li> <li>Implants (endosteal)</li> </ul>	50%
<b>Orthodontia Services</b> <ul style="list-style-type: none"> <li>Orthodontic treatment: No age limit</li> <li>\$1,500 per member lifetime maximum benefit</li> </ul>	50%

### **Dental Exclusions**

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service for an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury, as required by federal law.

**Aesthetic Dental Procedures:** Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

**Antimicrobial Agents:** Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

#### **Collection of Cultures and Specimens**

**Condition Caused By Active Participation in a War or Insurrection:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.

**Condition Incurred In or Aggravated During Performances In the Uniformed Services:** The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

#### **Connector Bar or Stress Breaker**

**Cosmetic/Reconstructive Services and Supplies** except for dentally appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as result of injury or illness.

**Desensitizing:** Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

#### **Diagnostic Casts or Study Models**

#### **Duplicate X-Rays**

**Expenses Before Coverage Begins or After Coverage Ends:** Services and supplies incurred before your effective date under the contract or after your termination under the contract except as may be provided under the other continuation options of the contract.

**Facility Charges:** Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

**Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest or finance charges that a dentist might bill.

**Fractures of the Mandible:** Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

#### **Gold-Foil Restorations**

**Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program.

#### **Home Visits**

**Implants:** Services and supplies provided in connection with implants, whether or not the implant itself is covered.

**Investigational Services:** Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures (health interventions).

**Medications and Supplies** including take home drugs, pre-medications, therapeutic drug injections and supplies.

#### **Motor Vehicle Coverage and Other Insurance Liability**

#### **Nitrous Oxide**

**Non-Direct Patient Care** including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges.

**Occlusal Treatment:** Services and supplies provided in connection with dental occlusion, including occlusal analysis, adjustments and occlusal guards.

#### **Oral Hygiene Instructions**

**Oral Surgery** treating any fractured jaw and orthognathic surgery. By orthognathic surgery, we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

**Personal Comfort Items:** Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.

#### **Photographic Images**

#### **Pin Retention in Addition to Restoration**

#### **Precision Attachments**

**Prosthesis** including maxillofacial prosthetic procedures and modification of removable prosthesis following implant surgery.

#### **Provisional Splinting**

**Replacements:** Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.



### ***Dental Exclusions***

**Riot, Rebellion and Illegal Acts:** Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.

#### **Self-Help, Self-Care, Training or Instructional Programs**

**Separate Charges:** Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure) including any supplies, local anesthesia and sterilization.

#### **Services and Supplies Provided by a Member of Your Family**

#### **Services Performed in a Laboratory**

**Surgical Procedures:** Services and supplies provided in connection with the following surgical procedures: exfoliative cytology sample collection or brush biopsy; incision and drainage of abscess extraoral soft tissue, complicated or non-complicated; radical resection of maxilla or mandible; removal of nonodontogenic cyst, tumor or lesion; surgical stent and surgical procedures for isolation of a tooth with rubber dam.

#### **Temporomandibular Joint (TMJ) Dysfunction Treatment**

**Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is or may be responsible.

**Tooth Transplantation:** Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

#### **Travel and Transportation Expenses**

**Work-Related Conditions:** Expenses for services and supplies incurred as a result of any work related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

**Please note:** This benefit summary provides a brief description of your dental plan benefits, limitations and exclusions under your dental plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our Website, **[www.myRegence.com](http://www.myRegence.com)**. Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply and a definition of dentally appropriate.



# Regence

Regence BlueCross BlueShield of Utah is an  
Independent Licensee of the Blue Cross and Blue  
Shield Association

Contact Customer Service at 1 (888) 367-2119

**[www.regence.com](http://www.regence.com)**

# PEHP Life and Accident

PEHP offers two ways to assure your loved-ones' well-being in the event of your death or disability.

PEHP Term Life offers up to \$500,000 of coverage. You may also apply for coverage for your spouse and/or dependent children.

PEHP Group Accident Plan provides benefits:

- » For death due to an accident on or off the job;
- » For permanent loss of speech, hearing, eyesight, or limb function due to an accident;
- » To supplement lost wages;
- » To cover out-of-pocket expenses beyond what your medical plan pays.

Don't wait another day to protect yourself and your family from the unforeseen.

## Group Term Life Coverage

### EMPLOYEE BASIC COVERAGE

Your employer funds basic coverage at no charge to you.

COVERAGE	AMOUNT
Up to Age 70	25,000
Age 71 to 75	12,500
Age 76 and over	6,250

### LINE-OF-DUTY DEATH BENEFIT

If you're enrolled in basic coverage, you get an additional \$50,000 Line-of-Duty Death Benefit at no extra cost. Enrollment is automatic.

### ACCIDENTAL DEATH RIDER

If you're enrolled in basic coverage, you get an additional \$20,000 Accidental Death Benefit at no extra cost. Enrollment is automatic.

### EVIDENCE OF INSURABILITY

You must submit evidence of insurability if:

- » You want more coverage than the guaranteed issue.
- » You apply for any amount of coverage 60 days after your hire date.

After you apply for coverage, PEHP will guide you through the necessary steps to get evidence of insurability. They may include:

- » Completing a health questionnaire.
- » Basic biometric testing and blood work.
- » Furnishing your medical records.

### EMPLOYEE ADDITIONAL TERM COVERAGE

If you apply within 60 days of your hire date, you can buy up to \$200,000 as guaranteed issue. After 60 days or for coverage greater than \$200,000 you must provide evidence of insurability.

Biweekly Rates	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.16	1.75	2.30	3.46	4.62	5.78	6.94	8.06	9.22	10.37	11.52
Age 30 to 35	1.23	1.86	2.47	3.68	4.92	6.15	7.38	8.60	9.83	11.05	12.28
Age 36 to 40	1.73	2.61	3.48	5.21	6.94	8.69	10.42	12.15	13.90	15.63	17.36
Age 41 to 45	2.12	3.20	4.25	6.37	8.51	10.62	12.76	14.86	16.99	19.11	21.23
Age 46 to 50	4.03	6.04	8.06	12.08	16.11	20.14	24.16	28.19	32.22	36.23	40.27
Age 51 to 55	4.84	7.25	9.67	14.49	19.33	24.16	29.00	33.82	38.66	43.49	48.33
Age 56 to 60	7.71	11.58	15.43	23.16	30.88	38.59	46.30	54.02	61.75	69.47	77.18
Age 61 to 70	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
After age 70, rates remain constant and coverage changes											
Coverage Amounts	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
Age 71 to 75	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 76 and over	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

# PEHP Life and Accident

## SPOUSE TERM COVERAGE

If you apply within 60 days of your hire date or date of marriage, you can buy up to \$50,000 as guaranteed issue for your spouse. After 60 days or for coverage greater than \$50,000 you will need evidence of insurability.

Biweekly Rates	25,000	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	0.59	1.16	1.75	2.30	3.46	4.62	5.78	6.94	8.06	9.22	10.37	11.52
Age 30 to 35	0.63	1.23	1.86	2.47	3.68	4.92	6.15	7.38	8.60	9.83	11.05	12.28
Age 36 to 40	0.88	1.73	2.61	3.48	5.21	6.94	8.69	10.42	12.15	13.90	15.63	17.36
Age 41 to 45	1.07	2.12	3.20	4.25	6.37	8.51	10.62	12.76	14.86	16.99	19.11	21.23
Age 46 to 50	2.01	4.03	6.04	8.06	12.08	16.11	20.14	24.16	28.19	32.22	36.23	40.27
Age 51 to 55	2.41	4.84	7.25	9.67	14.49	19.33	24.16	29.00	33.82	38.66	43.49	48.33
Age 56 to 60	3.85	7.71	11.58	15.43	23.16	30.88	38.59	46.30	54.02	61.75	69.47	77.18
Age 61 to 70	6.54	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
After age 70, rates remain constant and coverage changes												
Coverage Amounts	6.54	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
Age 71 to 75	12,500	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 76 and over	6,250	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

## DEPENDENT CHILDREN COVERAGE

If you apply within 60 days of your hire date, you can buy any available amount of coverage for dependent children. After 60 days, any new application for coverage or increase in coverage will require evidence of insurability. All eligible children will be covered at the same level.

Coverage Amount	5,000	10,000	15,000
Biweekly cost	0.24	0.48	0.72

# PEHP Life and Accident

## Accidental Death and Dismemberment (AD&D)

AD&D provides benefits for death and loss of use of limbs, speech, hearing or eyesight due to an accident, subject to the limitations of the policy.

### INDIVIDUAL PLAN

You select coverage ranging from \$25,000 to \$250,000.

### FAMILY PLAN

- » You select coverage ranging from \$25,000 to \$250,000, and your spouse and dependents will be automatically covered as follows:
  - › Your spouse will be insured for 40% of your coverage amount. If you have no dependent children, your spouse's coverage increases to 50% of yours;
  - › Each dependent child is insured for 15% of your coverage amount. If you have no spouse, each eligible dependent child's coverage increases to 20% of yours.
- » If an injury results in any of the losses shown below within one year of the date of the accident, the plan will pay the amount shown in the opposite column. The total amount payable for all such losses as a result of any one accident will not exceed the principal sum. The principal sum applicable to the insured person is the amount specified on the enrollment form.

FOR LOSS OF	BENEFIT PAYABLE
Life	Principal Sum
Two Limbs	Principal Sum
Sight of Two Eyes	Principal Sum
Speech and Hearing (both ears)	Principal Sum
One Limb or Sight of One Eye	Half Principal Sum
Speech or Hearing (one ear)	Half Principal Sum
Use of Two Limbs	Principal Sum
Use of One Limb	Half Principal Sum
Thumb and Index Finger On Same Hand	Quarter Principal Sum

## AD&D Coverage and Cost

INDIVIDUAL PLAN				FAMILY PLAN		
Coverage Amount	Biweekly Cost	Semi-Monthly Cost	Monthly Cost	Biweekly Cost	Semi-Monthly Cost	Monthly Cost
25,000	0.43	0.46	0.92	0.58	0.62	1.24
50,000	0.85	0.92	1.84	1.14	1.24	2.48
75,000	1.28	1.38	2.76	1.72	1.86	3.72
100,000	1.69	1.84	3.68	2.28	2.48	4.96
125,000	2.12	2.30	4.60	2.85	3.10	6.20
150,000	2.54	2.76	5.52	3.42	3.72	7.44
175,000	2.97	3.24	6.48	3.99	4.34	8.68
200,000	3.39	3.68	7.36	4.57	4.96	9.92
225,000	3.82	4.14	8.28	5.13	5.58	11.16
250,000	4.23	4.60	9.20	5.71	6.20	12.40

### LIMITATIONS AND EXCLUSIONS

Refer to the Group Term Life and Accident Plan Master Policy for details on plan limitations and exclusions. Call 801-366-7495 or visit [www.pehp.org](http://www.pehp.org) for details.

# PEHP Life and Accident

## Accident Weekly Indemnity

- » Employee coverage only
- » If you enroll in AD&D, you may also buy Accident Weekly Indemnity, which provides a weekly income if you are totally disabled due to an accident that is not job related.
- » The maximum eligible weekly amount is based on your monthly gross salary at the time of enrollment. You may buy coverage less than the eligible monthly gross salary, but may not exceed the eligible monthly gross salary.

### Accident Weekly Indemnity Coverage and Cost

MONTHLY GROSS SALARY IN DOLLARS	MAXIMUM AMOUNT OF WEEKLY INDEMNITY	BIWEEKLY COST	SEMI-MONTHLY COST	MONTHLY COST
250 and under	25	0.12	0.14	0.28
251 to 599	50	0.24	0.26	0.52
600 to 700	75	0.35	0.38	0.76
701 to 875	100	0.46	0.50	1.00
876 to 1,050	125	0.58	0.64	1.28
1,051 to 1,200	150	0.70	0.76	1.52
1,201 to 1,450	175	0.81	0.88	1.76
1,451 to 1,600	200	0.93	1.02	2.04
1,601 to 1,800	225	1.04	1.14	2.28
1,801 to 2,164	250	1.16	1.26	2.52
2,165 to 2,499	300	1.39	1.50	3.02
2,500 to 2,899	350	1.62	1.76	3.52
2,900 to 3,599	400	1.86	2.02	4.04
3,600 and over	500	2.32	2.52	5.04

## Accident Medical Expense

- » Employee coverage only
- » Helps you pay for medical expenses in excess of those covered by all group insurance plans and no-fault automobile insurance.
- » Will provide up to \$2,500 to help cover medical expenses incurred due to an accident that is not job related.

### Accident Medical Expense Coverage and Cost

MEDICAL EXPENSE COVERAGE	BIWEEKLY COST	SEMI-MONTHLY COST	MONTHLY COST
\$ 2,500	\$ 0.38	\$ 0.42	\$ 0.84

## Master Policy

This brochure provides only a brief overview. Complete terms and conditions governing these plans are available in the Group Term Life and Accident Plan Master Policy. It's available via your online personal account at [www.pehp.org](http://www.pehp.org). Contact PEHP to request a copy.

# PEHP Long-Term Disability

Did you know that you may have a Long-Term Disability (LTD) benefit paid for by your employer?

The PEHP LTD benefit may pay a portion of your salary and medical coverage if you have an accident, disease, illness, or are physically disabled due to a line-of-duty related injury. To qualify for LTD you must be disabled and unable to return to work for more than three months. The application process should begin when you stop working.

You must apply for LTD within six months from your last day worked in your regular job.

For more information, visit [www.pehp.org](http://www.pehp.org) and login to your online personal account. Or contact the PEHP LTD department at: 801-366-7583 or 800-365-7347.



## PEHP Eyewear Only (Plan F)

### Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on [eyemed.com](http://eyemed.com) or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

### SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
<b>Frames</b>	\$0 Copay, \$130 allowance, 20% off balance over \$130	Up to \$65
<b>Standard Plastic Lenses</b>		
Single Vision	\$10 Copay	Up to \$25
Bifocal	\$10 Copay	Up to \$40
Trifocal	\$10 Copay	Up to \$55
Lenticular	\$10 Copay	Up to \$55
Standard Progressive Lens	\$75 Co-pay	Up to \$40
Premium Progressive Lens <sup>A</sup>	\$95 Co-pay - \$120 Co-pay	
Tier 1	\$95 Co-pay	Up to \$40
Tier 2	\$105 Co-pay	Up to \$40
Tier 3	\$120 Co-pay	Up to \$40
Tier 4	\$75 Co-pay, 80% of charge less \$120 allowance	Up to \$40
<b>Lens Options</b> (paid by the member in addition to the price of the lenses)		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate-Adults	\$40	N/A
Standard Polycarbonate-Kids under 19	\$40	N/A
Standard Anti-Reflective Coating	\$45	N/A
Premium Anti-Reflective Coating <sup>A</sup>	\$57 - \$68	N/A
Tier 1	\$57	N/A
Tier 2	\$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	\$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
<b>Contact Lenses</b> (Contact lens allowance includes materials only)		
Conventional	\$0 Copay, \$130 Allowance, 15% off balance over \$130	Up to \$104
Disposable	\$0 Copay, \$130 Allowance, plus off balance over \$130	Up to \$104
Medically Necessary	\$0 Copay, Paid in Full	Up to \$200
<b>Laser Vision Correction</b>		
LASIK or PRK from U.S. Laser Network	\$2.94 off the retail price or 5% off the promotional price	N/A
	\$4.67	
	\$6.40	
<b>Hearing Care</b>		
Hearing Health Care from Amplifon Hearing Health Care Network	40% off exams and a low price guarantee on discounted hearing aids	N/A
<b>Frequency</b>		
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
<b>Premiums--monthly</b>		
Single	\$6.26	
Double	\$9.91	
Family	\$13.56	
<b>Additional Discounts</b> (Additional discounts are not insured benefits)		
Complete pair of prescription eyeglasses	40% off	
Non-prescription sunglasses	20% off	
Remaining balance beyond plan coverage	20% off	

#### Bi-Weekly Rate

Benefits are not provided from services or materials arising from: Orthopedic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered - fund as a Bifocal lens. Standard Progressive lens covered - fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. <sup>A</sup>Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.



## PEHP Full (Plan H)

### SUMMARY OF BENEFITS

#### Additional discounts

**40% OFF**

Complete pair of prescription eyeglasses

**20% OFF**

Non-prescription sunglasses

**20% OFF**

Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

#### Take a sneak peek before enrolling

- You're **Bi-Weekly Rate** **RIGHT** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on [eyemed.com](http://eyemed.com) or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

#### Vision Care Services

Exam With Dilation as Necessary

Retinal Imaging

Frames

#### Standard Plastic Lenses

Single Vision

Bifocal

Trifocal

Lenticular

Standard Progressive Lens

Premium Progressive Lens<sup>a</sup>

Tier 1

Tier 2

Tier 3

Tier 4

#### Lens Options

UV Treatment

Tint (Solid and Gradient)

Standard Plastic Scratch Coating

Standard Polycarbonate—Adults

Standard Polycarbonate—Kids under 19

Standard Anti-Reflective Coating

Premium Anti-Reflective Coating<sup>a</sup>

Tier 1

Tier 2

Tier 3

Photochromic/Transitions

Polarized

Other Add-Ons and Services

#### In-Network Member Cost

\$10 Co-pay

Up to \$39

\$0 Co-pay, \$100 Allowance, 20% off balance over \$100

\$10 Co-pay

\$10 Co-pay

\$10 Co-pay

\$10 Co-pay

\$75 Co-pay

\$95 Co-pay - \$120 Co-pay

\$95 Co-pay

\$105 Co-pay

\$120 Co-pay

\$75 Co-pay, 80% of charge less \$120 Allowance

\$15

\$15

\$15

\$40

\$40

\$45

\$57-\$68

\$57

\$68

80% of charge

\$75

20% off retail

20% off retail

#### Out-of-Network Reimbursement

Up to \$30

N/A

Up to \$50

Up to \$25

Up to \$40

Up to \$55

Up to \$55

Up to \$40

Up to \$40

Up to \$40

Up to \$40

Up to \$40

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

#### Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)

Standard Contact Lens Fit & Follow-Up

Up to \$55

N/A

Premium Contact Lens Fit & Follow-Up

10% off retail price

N/A

#### Contact Lenses (Contact lens allowance includes materials only)

Conventional

\$0 Co-pay, \$120 Allowance, 15% off balance over \$120

Up to \$96

Disposable

\$0 Co-pay, \$120 Allowance; plus balance over \$120

Up to \$96

Medically Necessary

\$0 Co-pay, paid-in-full

Up to \$200

#### Laser Vision Correction

LASIK or PRK from U.S. Laser Network

\$3.40

\$5.56

\$7.71

3% off the retail price or 5% off the promotional price

#### Hearing Care

Hearing Health Care from Amplifon Hearing

40% off exams and a low price guarantee on

N/A

Health Care Network

discounted hearing aids

#### Frequency

Examination

Once every 12 months

Lenses or Contact Lenses

Once every 12 months

Frame

Once every 12 months

#### Premiums—monthly

Single

\$7.24

Double

\$11.80

Family

\$16.33

Benefits are not provided from services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. <sup>a</sup>Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.



# Know-how and show-how

## SUPPORT WHEREVER YOU ARE, WHATEVER YOU'RE DOING

Eye care is an experience. From the day you enroll to the day you find your favorite frames, we'll be part of it. Guiding. Advising. Helping you make the most of your vision benefits.

We go out of our way to make your benefits easy to understand – and even easier to experience.

## MAKING LIFE EASIER EVERY DAY



### WELCOME KIT

You've probably already seen your Welcome Kit in the mail. It'll give you a head start with benefit details, the 10 closest eye doctors and your ID card.



### MEMBER APP

Our member app is like a personal assistant. Find an eye doctor. Make an appointment. Pull up your ID card and eyewear prescription anytime.



### CALL CENTER

Get live help from one of America's highest-rated call centers. Our call center resolves 99.4% of issues during the first call.



### VISION AIDS

Get guidance from the vision experts at [eyesiteonwellness.com](http://eyesiteonwellness.com). Plus learn how to maximize your benefits and get special offers when you sign up for inSIGHTS at [eyemed.com](http://eyemed.com).



### TEXT ALERTS

Get updates and reminders, tips to maximize your benefits and extra ways to save money – right to your mobile device. **Call 844.873.7853 to opt in.** Be sure to have your 9-digit Member ID handy.



### MEMBER WEB

Manage your vision benefits, find an eye doctor, print ID cards, get special offers and more on [eyemed.com](http://eyemed.com).

## SEE THE GOOD STUFF

Register on [eyemed.com](http://eyemed.com) or grab the member app (App Store or Google Play) now.





# Keep an eye on your money

## MEMBERS-ONLY SPECIAL OFFERS

You deserve special savings just for being an EyeMed member. So we've developed a page on [eyemed.com](http://eyemed.com) that only registered members can see. It's the latest list of special offers for vision-related products and services. A mix of member discounts and extra savings that give your benefits a boost. So you can keep your eyes healthy and save some cash while you're at it.

## UNLOCK YOUR OFFERS IN MINUTES

Just go to [eyemed.com](http://eyemed.com), register and you're set to shop the savings. And if you have the EyeMed Members App, pull up the offer at the store—no printing!

New offers are added often, so check before you go.



- Discounts on frames and lenses
- Savings on contacts
- Exclusive offers from network providers and retailers
- Free shipping from online providers
- Free vision products, like lens cleaner kits and more, all from trusted EyeMed network providers

## SEE THE GOOD STUFF

Register on [eyemed.com](http://eyemed.com) or grab the member app (App Store or Google Play) now.

INDEPENDENT  
PROVIDER  
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OPTICAL





## PEHP 0-150/140C (Exam & Hardware)

### Premium Rates

Single	\$8.56
Two-Party	\$13.27
Family	\$18.99

### 2020-2021 Enhanced Benefits

#### New Plan

#### Better Benefits

#### Larger Frame Allowance

#### Unlimited Network Options

#### No Co Pay Options\*

SCHEDULE ONLINE



NETWORKS	Standard Optical Select Network	In Network	Out of Network
<b>Comprehensive Eye Exam</b>	<b>Covered 100%</b>	<b>\$10 Co Pay</b>	<b>\$40 Allowance</b>
Retinal Imaging	\$20 Co Pay	\$39 Co Pay	Incl. Above
<b>Frame Allowance</b>	<b>\$150.00</b>	<b>\$130.00</b>	<b>\$70.00</b>
Additional Pairs of RX Glasses	50% Off	25-50% off	
<b>Plastic Lens Benefit</b>			
Single Vision	\$0 Co Pay - Covered 100%	\$10 Co Pay	\$70 Allowance
BiFocal	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Trifocal	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Standard Progressive	\$30 Co Pay	\$50 Co Pay	
Digital Progressive (MasterpieceHD)	\$80 Co Pay	\$100 Co Pay	
<b>Options &amp; Coatings</b>			
UV	\$0 Co Pay - Covered 100%	\$10 Co Pay	Incl. Above
TINT	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Scratch	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Poly Kids (Under age 19)	\$20 Co Pay	\$40 Co Pay	
Poly Adult	\$40 Co Pay	\$40 Co Pay	
Premium Anti Reflective	\$50 Co Pay	25% Off	
Transitions/Photochromic	\$50 Co Pay	\$75 Co Pay	
BluDefense Digital (includes AR)	\$100 Co Pay	NA	
Polarized	25% Discount	0-25% Discount	
Other Add-ons	25% Discount	0-25% Discount	
<b>Contact Lenses</b>			
<b>Allowance - Conventional</b>	<b>\$140.00</b>	<b>\$130.00</b>	<b>\$100.00</b>
<b>Allowance - Disposable</b>	<b>\$140.00</b>	<b>\$130.00</b>	<b>\$100.00</b>
Medically Necessary	\$0 Co Pay - Covered 100%	\$250 Allowance	NA
CL Fit & Follow Up Fee			
Standard Spherical	\$0 Co Pay - Covered 100%	\$40 Co Pay	
Specialty Toric or Multifocal	\$40 Co Pay	\$80 Co Pay	
Additional Discounts	Up to 20% Discount	Up to 10% Discount	
Non-RX (Plano Sunglasses)	25% Discount	20% Discount	
All other options	25% Discount	20% Discount	
<b>Refractive Procedures</b>			
LASIK (iDesign All Laser LASIK)	20% off retail or 10% off promo price	NA	NA
Visian ICL	20% off retail or 10% off promo price	NA	NA
<b>Dry Eye Treatments</b>			
Punctal Occlusion	\$250/puncta silicone	NA	NA
Punctal Occlusion Nutraceuticals	\$75/puncta collagen	NA	NA
MacuHealth Formula	10% Discount		
Blink Dry Eye Formula	10% Discount		

Discounts: Any item listed as a discount is a merchandise discount only and not an insured benefit. Discounts vary by providers, see provider for details.

\*Up to 20% Discount off balance above Frame Allowance.

\*\* 50% discount varies by provider, ask provider for details.

\*\*\* Must purchase full year supply to receive discounts on select brands. See provider for details.

\*\*\*\* LASIK (Refractive surgery) Standard Optical Locations ONLY. LASIK services are not an insured benefit – this is a discount only.

All pre & post operative care is provided by Standard Optical only and is based on Standard Optical retail fees.

Out of Network: Out of Network benefit may not be combined with promotional items. Online purchases at approved providers only.

For more Information please visit [www.opticareofutah.com](http://www.opticareofutah.com) or call (800) 363-0950.

Restrictions apply. Opticare Vision Services underwritten by and a wholly owned subsidiary of Opticare of Utah, Inc.

Opticare Vision Services  
(800) 363-0950  
[www.opticareofutah.com](http://www.opticareofutah.com)  
[www.opticarevisionservices.com](http://www.opticarevisionservices.com)



## PEHP 150/140C (Hardware Only)

### Premium Rates

Single	\$6.65
Two-Party	\$9.94
Family	\$13.94

### 2020-2021 Enhanced Benefits

#### New Plan

#### Better Benefits

#### Larger Frame Allowance

#### Unlimited Network Options

#### No Co Pay Options\*

SCHEDULE ONLINE



NETWORKS	Standard Optical Select Network	In Network	Out of Network
No Exam - Hardware Only Plan			
<b>Frame Allowance</b>	<b>\$150.00</b>	<b>\$130.00</b>	<b>\$70.00</b>
Additional Pairs of RX Glasses	50% Off	25-50% off	
<b>Plastic Lens Benefit</b>			
Single Vision	\$0 Co Pay - Covered 100%	\$10 Co Pay	\$70 Allowance
BiFocal	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Trifocal	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Standard Progressive	\$30 Co Pay	\$50 Co Pay	
Digital Progressive (MasterpieceHD)	\$80 Co Pay	\$100 Co Pay	
<b>Options &amp; Coatings</b>			
UV	\$0 Co Pay - Covered 100%	\$10 Co Pay	Incl. Above
TINT	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Scratch	\$0 Co Pay - Covered 100%	\$10 Co Pay	
Poly Kids (Under age 19)	\$20 Co Pay	\$40 Co Pay	
Poly Adult	\$40 Co Pay	\$40 Co Pay	
Premium Anti Reflective	\$50 Co Pay	25% Off	
Transitions/Photochromic	\$50 Co Pay	\$75 Co Pay	
BluDefense Digital (includes AR)	\$100 Co Pay	NA	
Polarized	25% Discount	0-25% Discount	
Other Add-ons	25% Discount	0-25% Discount	
<b>Contact Lenses</b>			
<b>Allowance - Conventional</b>	<b>\$140.00</b>	<b>\$130.00</b>	<b>\$100.00</b>
<b>Allowance - Disposable</b>	<b>\$140.00</b>	<b>\$130.00</b>	<b>\$100.00</b>
Medically Necessary	\$0 Co Pay - Covered 100%	\$250 Allowance	NA
CL Fit & Follow Up Fee			
Standard Spherical	\$0 Co Pay - Covered 100%	\$40 Co Pay	
Specialty Toric or Multifocal	\$40 Co Pay	\$80 Co Pay	
Additional Discounts	Up to 20% Discount	Up to 10% Discount	
Non-RX (Plano Sunglasses)	25% Discount	20% Discount	
All other options	25% Discount	20% Discount	
<b>Refractive Procedures</b>			
LASIK (iDesign All Laser LASIK)	20% off retail or 10% off promo price	NA	NA
Visian ICL	20% off retail or 10% off promo price	NA	NA
<b>Dry Eye Treatments</b>			
Punctal Occlusion	\$250/puncta silicone	NA	NA
Punctal Occlusion Nutraceuticals	\$75/puncta collagen	NA	NA
MacuHealth Formula	10% Discount		
Blink Dry Eye Formula	10% Discount		

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[www.opticarevisionservices.com](http://www.opticarevisionservices.com)




# Visit Our Providers

**Want to visit an Opticare of Utah participating preferred provider?**

We have over 100 providers located in the State of Utah and over 18,000 nationwide.

**To locate a provider in your area view our website:**

[www.opticareofutah.com](http://www.opticareofutah.com)

From the home page, click  an Opticare Provider and search by network choice (Select or Broad).

There you will find a selection of optical chains and independent private practice offices.

**Needing to visit one of our nationwide providers?**

Simply find a provider by searching with the Out-of-State network option searchable by zip code.

**Need help or have questions?**

Contact us:

(801) 869-2020 or (800) 363-0950

[service@opticareofutah.com](mailto:service@opticareofutah.com)

## Select In-Network



## Broad In-Network



# Your Benefits, Your Way

**Whatever your style of learning,**  
URS is here to help you understand  
your retirement benefits.



## Website

Go to **www.urs.org** for information about your pension and savings plans. Log in to **myURS** to manage investments, beneficiaries, and more.



## Publications

Understand your pension, savings plans options, retirement information, and more. Find publications at **www.urs.org**. Or email **publications@urs.org** to request printed copies.

## Videos

Learn how to manage your benefits online and more.



## Seminars

Held throughout the year, seminars provide an overview of your benefits and more. **www.urs.org/US/seminars**

## Webinars

Learn at your own computer or device. See schedule at **www.urs.org/US/webinars**. Archived webinars are available.

## One-on-One

Meet face-to-face with a URS Retirement Planning Advisor for custom retirement guidance. Schedule a free session at **myURS** at **www.urs.org**.

## Via Phone

We look forward to answering your questions. Call weekdays between 8 a.m. and 5 p.m., **801-366-7770** or **800-695-4877**.





# Navigate a Secure Future

## Free URS Seminars held across Utah

Take the first step toward a more financially secure future by attending a URS seminar. To register, log in to myURS at [www.urs.org](http://www.urs.org) and click "Education." Space is limited, so reserve your spot soon!

## 2020

### Early to Mid-Career Seminars 8:30 a.m. - 1 p.m. Planning for a secure future

SLC - Granite ..... June 5      Cottonwood Heights Sept. 11

### Pre-Retirement Seminars 9 a.m. - 4 p.m. Critical if you're within 10 years of retirement

SLC - Central.....	March 13	North Logan.....	July 17
Draper.....	May 15	Farmington.....	July 30
Santa Clara.....	May 28	SLC - Granite.....	Aug. 5
Spanish Fork.....	June 9	Ogden.....	Sept. 25
Farmington.....	June 12	Provo.....	Oct. 9
Riverton.....	June 19	SLC - Central.....	Nov. 6
Heber.....	June 26		

### Retiree Seminar 8:30 a.m. - 4 p.m. Important tips and strategies for retirees

SLC - Granite..... Sept. 16

## Seminar Locations:

**Cottonwood Heights**  
City Hall  
2277 East Bengal Blvd.

**Draper**  
City Hall  
1020 East Pioneer Rd. (12400 South)

**Farmington**  
Davis School District Offices  
70 East 100 North  
Kendell Building, 2nd Floor

**Heber**  
Wasatch High School  
930 South 500 East

**North Logan**  
Cache County School District  
Legacy Campus - Technology  
Building  
2035 North 1200 East

**Ogden**  
Weber Center  
Commission Chambers  
2380 Washington Blvd.

**Provo**  
Utah County Health  
and Justice Building  
151 South University Ave.

**Riverton**  
Jordan Academy  
for Technology and Careers  
South Campus  
12723 South Park Ave.

**SLC - Central**  
Salt Lake County  
Government Center  
2001 South State St.  
Commission Chambers  
Room N1100

**SLC - Granite**  
Granite Education Center  
2500 South State St.  
Auditorium A

**Spanish Fork**  
Nebo School District  
350 South Main St.  
Board Room

**Santa Clara**  
Santa Clara City Offices  
2603 Santa Clara Dr.

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